

**Georgia Composite Medical Board Use Only**

File Number: \_\_\_\_\_ License Number: \_\_\_\_\_

Date Reinstated: \_\_\_\_\_

**Reinstatement Physician Application**

All fees are nonrefundable and subject to change.

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**Name and Personal Detail**

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. § 651 and 20 U.S.C.A. § 1001. This information may also be disclosed to the National Practitioner Data Bank or other state medical boards or regulatory agencies for license tracking purposes.

Social Security Number \_\_\_\_\_

Last Name (Surname) \_\_\_\_\_

First \_\_\_\_\_

Middle \_\_\_\_\_

Other Surnames \_\_\_\_\_

Degree ☐ MD ☐ DO Specialty \_\_\_\_\_Gender ☐ Male ☐ Female

Birth Date (mm/dd/yy) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**Contact Detail Summary****General Addresses**

**Mailing Address:** Correspondence from the Board is sent to this address. Email address is utilized by the Board to contact you in case of an emergency situation. ***This address will not appear on the Internet if you fail to provide a practice location address prior to approval.***

\_\_\_\_\_  
Street Number    Street Name    City    State    Zip    Apt\_\_\_\_\_  
Area Code    Phone Number    Email

**Practice Location:** Posted on the Internet when the license number is issued.

\_\_\_\_\_  
Street Number    Street Name    City    State    Zip    Suite/Bldg\_\_\_\_\_  
Area Code    Phone Number



## Reinstatement Physician Application

### Hospital Privileges

**INSTRUCTIONS:** ALL applicants must complete this section. If you had no hospital privileges, please check the box below. Copy this page if more space is needed to list hospitals where privileges were held.

☐ **NONE**

*Hospital*

*Address*

*City/State/Zip*

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*Hospital*

*Address*

*City/State/Zip*

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*Hospital*

*Address*

*City/State/Zip*

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*Hospital*

*Address*

*City/State/Zip*

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*Hospital*

*Address*

*City/State/Zip*

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*Hospital*

*Address*

*City/State/Zip*

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## Reinstatement Physician Application

### Applicant Questionnaire:

**“Yes” responses require a personal explanation and supporting documentation.**

	YES	NO
1. During the last 7 years, have you suffered from any physical, psychiatric, or substance use disorder that could impair or require limitations on your functioning as a professional or has resulted in the inability to practice medicine for more than 30 days, or required court-ordered treatment or hospitalization? (If yes, provide treatment history documentation to include diagnosis, treatment regimen, hospitalization, and ongoing treatment/medication to the Board. <b>NOTE: If you are currently enrolled in GAPHP, you may check NO.</b>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you entered a plea bargain, been arrested, indicted or convicted for violating any state or federal law including DUI (excluding minor traffic violations)? As used in this question, the term "conviction" shall include a finding or verdict of guilt, or a plea of guilty, or a plea of nolo contendere in a criminal proceeding, regardless of whether the adjudication of guilt or sentence is withheld or not entered.	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been denied the privilege of taking an examination given by any licensing Board or Agency?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any licensing Board or agency ever taken a <b>public or private</b> disciplinary action against your license?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has any licensing Board or agency ever refused you renewal of a certificate or a license?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been denied a DEA registration number?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been issued a restricted DEA registration?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you currently registered with the DEA? If yes, provide DEA number _____ and State of Issue _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been named as a party in a malpractice suit, arbitration hearing, State Review panel proceeding, or a VA/Federal agency review?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been denied membership in, or in any way sanctioned, by any medical or osteopathic association, society, or specialty society?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever resigned from a hospital staff position or training program after a complaint or peer review action has been initiated against you?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever voluntarily surrendered a medical license?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever voluntarily surrendered a controlled substance registration?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever voluntarily surrendered a DEA registration?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have any applications for licensure pending before any other licensing Board or agency? If yes, provide a list.	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had any restrictions as a Medicaid or Medicare provider?	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you in default on a state or federally funded and/or guaranteed school loan?	<input type="checkbox"/>	<input type="checkbox"/>
19. Are you in default on child support payments?	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you intend to practice medicine in Georgia? Please provide your plans below:	<input type="checkbox"/>	<input type="checkbox"/>
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21. Have you been practicing prior to reinstating your application:	<input type="checkbox"/>	<input type="checkbox"/>
22. Since your license has been on an inactive status or expired, what medical activities and continuing medical education activities have you been engaged in? _____		
23. Have you maintained 80-hours of Board approved CME in the last <b>four</b> years?	<input type="checkbox"/>	<input type="checkbox"/>



- If you are not a U.S. citizen, you must submit documentation that will determine if you have a qualified alien status. **Only those applicants who can provide proof will be granted a license.** The Board participates in the **DHS-USCIS SAVE** (Systematic Alien Verification for Entitlements or "SAVE") program for the purpose of verifying citizenship and immigration status information of non-citizens. In order to confirm your status with the SAVE program, you need to provide the board with **legible** copies of **one** of the documents listed on our checklist.

Provide history for each permanent, temporary, training, provisional, or limited licensed obtained in any state in the US, Canadian Territory or Province, or US Federal Jurisdiction.

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